

**IN THE CIRCUIT COURT OF LOUDON COUNTY, TENNESSEE
AT LOUDON**

DEBBORAH S. JAMES,

Plaintiff,

v.

**SUN LIFE ASSURANCE COMPANY
OF CANADA (U.S.), and
PROFESSIONAL INSURANCE
COMPANY,**

Defendants.

JURY DEMAND

NO.: 2010-CV-150

FILED
TIME 10:31 AM/PM

SEP 09 2010

LISA NILES
CIRCUIT COURT CLERK
Ron Beaty D.C.

COMPLAINT

COMES the Plaintiff, Debborah James (hereinafter "Plaintiff"), by and through the undersigned counsel of record, and hereby brings the following Complaint against Defendants Sun Life Assurance Company of Canada (U.S.) ("Sun Life"), and Professional Insurance Company:

PARTIES

1. At all relevant times Plaintiff was and is an adult resident of Loudon County, Tennessee.
2. Plaintiff alleges upon information and belief that Defendant Professional Insurance Company is a subsidiary of Defendant Sun Life, and both entities are insurance companies authorized to transact the business of insurance in this state.
3. Defendant Professional Insurance Company and/or Sun Life is the underwriter of and/or insurer of disability insurance policies issued to Plaintiff, said policies having, *inter alia*, the following identifying characteristics: Policy No. 00916014 (hereinafter "Policy 6014"), and Policy No. 00916015 (hereinafter "Policy

6015"). Collectively, Policy 6014 and Policy 6015 will be referenced hereinafter as "Policies."

4. Defendant Professional Insurance Company may be served with process by serving the Commissioner of the Tennessee Department of Commerce and Insurance, 500 James Robertson Parkway, Suite 660, Nashville, Tennessee 37243-1121.
5. Defendant Sun Life may be served with process by serving the Commissioner of the Tennessee Department of Commerce and Insurance, 500 James Robertson Parkway, Suite 660, Nashville, Tennessee 37243-1121.

JURISDICTION AND VENUE

6. This is an action for damages for failure to pay benefits under an insurance policy and other related claims over which this court has jurisdiction.
7. Venue is proper in Loudon County, Tennessee.

FACTS

8. At all relevant times Plaintiff was employed by the Loudon County Department of Human Services (LCDHS) as a Field Supervisor.
9. While Plaintiff was employed by LCDHS, Plaintiff and/or LCDHS purchased disability insurance Policies (Policies 6014 and 6015) from Defendant Professional Insurance Company and/or Sun Life.
10. Defendant Professional Insurance Company and/or Sun Life are the entities responsible for processing claims and adjudicating appeals under the Policies.
11. Defendant Professional Insurance Company and/or Sun Life would pay any disability benefits due to Plaintiff under the Policies out of their own funds.

12. Plaintiff applied for coverage, was accepted, and was thereafter covered under said Policies 6014 and 6015 with the same effective date for both: April 1, 1990.
13. All premiums have been paid and Plaintiff has satisfied all the requirements for coverage under the above Policies, which are contracts for insurance.
14. Plaintiff, while covered under the Policies, suffered from and/or developed chronic back pain, including residual problems status post two back surgeries, and status post total knee replacement, on or about November 21, 2008, or thereafter, which caused then and/or subsequently, *inter alia*, pain, fatigue, physical restrictions and/or limitations, and problems with concentration or memory, all of which interfered with her ability to work, and ultimately caused her to become disabled.
15. On or about November 21, 2008, Plaintiff's medical condition caused her to have a complete inability to perform the material duties of her principal occupation, at which time she suffered a significant loss of earnings.
16. Since on or about November 21, 2008, Plaintiff has had a complete inability to perform the material duties of her principal occupation such that she has been unable to earn any income.
17. On or about November 21, 2008, Plaintiff applied for benefits under the Policies by submitting an insured's statement and, thereafter, by submitting, *inter alia*, numerous attending physician statements and medical records pursuant to the requirements of the Policies.
18. On July 29, 2009, Defendant Professional Insurance Company and/or Sun Life sent Plaintiff a letter explaining that no benefits were payable at this time and

requested additional information.

19. On several occasions, including January 12, 2010 and March 10, 2010, Plaintiff submitted additional information to Defendant Professional Insurance Company and/or Sun Life, including her treating physicians' medical records and medical opinions regarding her disability.
20. On June 24, 2010, Plaintiff requested that Defendant Professional Insurance Company and/or Sun Life make a favorable decision with respect to her disability benefits under the Policies.
21. Previously, on December 7, 2009, Plaintiff's counsel sent Defendant Professional Insurance Company and/or Sun Life a letter indicating that if it did not pay the benefits due under the Policies within 60 days that Plaintiff intended to seek penalties under Tenn. Code Ann. § 56-7-105.
22. The Plaintiff has received no benefits under the Policies.
23. Defendant Professional Insurance Company and/or Sun Life have failed to make a substantive decision as to whether Plaintiff is entitled to disability benefits under the Policies.

COUNT ONE

TENNESSEE BREACH OF CONTRACT

Plaintiff incorporates the allegations contained in paragraphs 1 through 23 as if fully stated herein and further states that:

24. Under the laws of the State of Tennessee, Plaintiff was covered under the Policies and said Policies constitute contracts for insurance coverage.
25. Under the laws of the State of Tennessee, Plaintiff made a valid and timely claim

for benefits under terms of the Policies and Defendants have refused to pay.

26. Under the laws of the State of Tennessee, all premiums have been paid and Plaintiff has met all other conditions precedent to have valid contracts for insurance coverage and has satisfied the terms of the contract entitling her to benefits under the contract.

27. Under the laws of the State of Tennessee, Defendants have breached, and continue to breach, their contractual duties under the insurance Policies by failing and refusing to pay the full requisite of benefits owed the Plaintiff and by failing to perform their duties as set out in the contracts.

28. Under the laws of the State of Tennessee, as a direct and proximate result of Defendants' breach, Plaintiff has suffered, and continues to suffer, substantial damages as previously set forth above.

COUNT TWO

VIOLATION OF THE TENNESSEE CONSUMER PROTECTION ACT

TENNESSEE CODE ANNOTATED § 47-18-101 AND § 47-18-109.

Plaintiff incorporates the allegations contained in paragraphs 1 through 28 as if fully stated herein and says further that:

29. Tennessee Code Annotated § 47-18-109 provides a private right of action to any person who suffers an ascertainable loss of money or property as a result of the use or employment by another person of an unfair or deceptive act or practice declared unlawful by the Consumer Protection Act.

30. The acts which are prohibited under the Consumer Protection Act are listed in Tennessee Code Annotated § 47-18-104. In addition to the specifically prohibited

acts, Tennessee Code Annotated § 47-18-104(b)(27) is a catch-all provision prohibiting all practices which are deceptive or unfair to customers.

31. By ignoring the terms of the disability insurance contracts and by giving the Plaintiff inadequate or misleading information about her claim, the Defendants have acted unfairly and deceptively.

32. As a direct and proximate result of the Defendants' conduct, Plaintiff has suffered and continues to suffer monetary loss and damages.

33. Through their handling of the Plaintiff's claim, the Defendants have willfully and knowingly violated the Tennessee Consumer Protection Act, Tennessee Code Annotated § 47-18-101 et seq., entitling Plaintiff to treble damages.

COUNT III

TENNESSEE BAD FAITH FAILURE TO PAY CLAIM

Plaintiff incorporates the allegations contained in paragraphs 1-33 as if fully stated herein and further states that:

34. At all times relevant to the matters alleged herein, Defendants were under a duty to use good faith in the handling of Plaintiff's claim.

35. Plaintiff's claim for benefits is due and payable and Plaintiff's application was filed on or about November 21, 2008, which constitutes a formal demand for payment, and Defendants have either failed or refused to pay further benefits.

36. Defendants impeded a legitimate and well-supported claim for benefits, which clearly shows an intent not to honor the terms of the Policies.

37. Defendants acted in bad faith in denying benefits to Plaintiff or in failing to timely make a decision on Plaintiff's claim.

38. As a direct and proximate result of Defendants' actions in handling this claim, Plaintiff has suffered, and continues to suffer, monetary loss and damages, including the need to hire an attorney to enforce the terms of contracts for insurance.

39. Because Defendants did not act in good faith in denying Plaintiff's claim for benefits, Defendants are liable under Tennessee Code Annotated § 56-7-105(a) for additional damages in an amount up to 25% of liability.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff requests that this Court grant her the following relief in this case:

That the Court enter judgment in favor of Plaintiff and against Defendants and that the Court order Defendants to perform their obligations under the contracts for insurance and to pay past due benefits to Plaintiff in an amount equal to the contractual amounts of benefits to which she is entitled.

That the Court order Defendants to pay Plaintiff prejudgment interest in all benefits that have accrued prior to the date of judgment;

That the Court order Defendants to pay Plaintiff prejudgment interest on all benefits that have accrued prior to the date of judgment;

That the Court order Defendants to continue paying benefits to Plaintiff until such time as she no longer qualifies for continuation of benefits.

That the Court order Defendants to pay treble damages pursuant to Tennessee Consumer Protection Act, Tennessee Code Annotated § 47-18-101 et seq.;

That the Court order Defendants to pay an additional 25% of the contractual

liability for bad faith handling of the claim, pursuant to Tennessee Code Annotated § 56-7-105(a);

That the Court order Defendants to pay Plaintiff's attorneys' fees and costs under applicable law, and,

That Plaintiff recover any and all other relief to which she may be entitled.
Plaintiff further demands a jury to hear her case.

Dated this 8th day of September, 2010.

Respectfully submitted,

ERIC BUCHANAN & ASSOCIATES, PLLC
ATTORNEYS FOR PLAINTIFF

BY: 

D. Sean Holliday (#023136)
414 McCallie Avenue
Chattanooga, Tennessee 37402
(423) 634-2506
(423) 634-2505 (fax)

PROFESSIONAL INSURANCE COMPANY

Home Office: Dallas, TX 75201

Administrative Office: 175 Addison Rd, P.O. Box 725, Windsor, CT 06095-0725 • 800-289-1122

Welcome to Professional Insurance Company, now a part of Sun Life Employee Benefits Group. For over 65 years, Professional Insurance Company has provided high quality, affordable supplemental insurance benefits to employees of small-to medium-sized businesses.

We are happy to enclose your new policy. Your new benefits were designed to help you enjoy greater peace of mind in the years to come.

Before you put your policy in a safe place, please read it carefully, including the copy of the application, to be sure you understand the policy provisions. Please notify us immediately if:

- you have questions about your coverage;
- there is any misstatement in the application, even though unintentional, or;
- any information about an insured person's medical history has been omitted or is inaccurate.

We look forward to serving you and appreciate the confidence you have placed in us. If you have any questions now or in the future, please write to our Policyholder's Service Department, or contact us at the telephone number listed above.



President

- 02289

DEBBORAH S JAMES
1620 TERRACE DRIVE
LOUDON, TN 37774

EFSWELCAH-F

Cut along dotted line and retain for identification

PROFESSIONAL INSURANCE COMPANY

This card identifies a Professional Insurance Company policyholder. Pre-certification is not required when the policyholder is hospitalized for any accident or sickness. A health care provider may confirm coverage provided by this policy by calling our Claim Department at the number listed below.

DEBBORAH S JAMES

00916014

1-800-289-1122

PO Box 80637 Lincoln, NE 68501

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DEBBORAH S JAMES

00916014

1-800-289-1122

PO Box 80637 Lincoln, NE 68501



Professional Insurance Company
In California, PIC Life Insurance Company
P.O. Box 80637, Lincoln, NE 68501

Privacy Notice

Professional Insurance Company
In California, PIC Life Insurance Company

Important information. No action required.

At Sun Life Financial and our family of companies, we appreciate your business and the trust you have placed in us. Our privacy philosophy reflects the value of your trust. We are committed to protecting the personal information (data) we obtain about you. We do not sell your data and we only use your data in the context of our business relationship. To further understand our Privacy Policy please review the following details.

The data we collect

We collect your data to provide you with the products or services you requested. We may obtain it from your application, your transactions with us, outside parties such as health providers, or consumer reporting agencies. We may collect data about you to process transactions or claims, to determine if you qualify for coverage, and to prevent fraud. Where required, we will obtain your consent before collecting it. The data may include:

- Name and address
- Social security number or taxpayer identification number
- Income and assets
- Accounts at other institutions
- Medical or health data
- Credit and payment data

What we do with your data

We comply with federal and state requirements related to the use and protection of your data. We only share data where we are permitted or required by law. We also may be required to obtain your authorization before disclosing certain types of data.

We may use your data in order to:

- Process transactions or claims
- Determine your eligibility for coverage
- Respond to your requests
- Prevent fraud
- Comply with regulatory requirements
- Share with you related products and services we offer

We do not sell data about current or former customers or their accounts. We do not share data for marketing purposes with anyone outside our family of companies. When affiliates or outside companies perform a service on our behalf, we may share your data with them. They are required to protect your data. These service providers are also required to use your data only to perform these services.

Examples of outside parties who may receive your data are:

- Your agent or representative
- Your brokerage firm
- Law enforcement
- State insurance, health care, or law enforcement authorities
- Other insurance companies
- Other carriers to coordinate benefits for your coverage
- Service providers for our business
- Your health care provider

How we protect your data

We restrict access to your data. To protect your data, we maintain physical, electronic, and procedural safeguards. We review these safeguards regularly in keeping with technological advancements. We also train our employees in the proper handling of your data.

We will keep you informed

We will send you the Policy each year while you are our customer. We may change our Policy. We will send you a new Policy if we broaden our data sharing practices.

HOW TO FILE A CLAIM

DISABILITY CLAIMS

When you need to file a PIC Disability claim:

1. Call 1-800-289-1122 to obtain a claim packet. The claim packet will contain a claim form, an authorization form, and a request for a list of providers.
2. FULLY COMPLETE the Claimant's portion of the claim form. Please sign and date the authorization. Include your policy number and social security number.
3. Have your Employer FULLY COMPLETE and SIGN the Employer's section of the claim form.
4. Have your doctor fully complete the Attending Physician's portion of the claim form.
5. In order to assist us in reviewing your claim as quickly as possible, please complete the Authorization to Obtain and Disclose Protected Health Information and Request for Additional Medical Information.
6. Send the fully completed forms to the address below.
7. Do not complete and/or submit your claim form prior to your disability.

HOSPITAL INDEMNITY/CANCER CLAIMS

When you need to file a Hospital Indemnity/Cancer claim:

1. Call 1-800-289-1122 to obtain a claim packet. The claim packet will contain a claim form, an authorization form, and a request for a list of providers.
2. FULLY COMPLETE the Claimant's portion of the claim form. Please sign and date the authorization. Include your policy number and patient information (Name, SSN and Date of Birth). Please also complete the enclosed authorization and request for additional medical information.
3. Attach copies of the following – UB-92 forms (hospital bills), HCFA forms (physician bills) or itemized bills that provide Dates of Service, Type of Service, Diagnosis and charges. NOTE: The UB-92 and HCFA forms allow for the quickest processing. You can ask your Doctor and/or hospital to provide these to you.
4. For Cancer claims, in addition to the items listed above, submit a copy of the positive pathology report.
5. Send the fully completed forms to the address below.

Taking these steps will insure that a claim will be processed as accurately and quickly as possible.

Professional Insurance Company
Employer Services Group
Claims Department
P.O. Box 85656
Lincoln, NE 68501-5656

PROFESSIONAL INSURANCE COMPANY

Home Office: Dallas, TX 75201

Administrative Office: 175 Addison Rd, P.O. Box 725, Windsor, CT 06095-0725 • 800-289-1122

DISABILITY INCOME POLICY

GUARANTEED RENEWABLE TO AGE 65. SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS.

You have the right to renew this policy until the first premium due date on or after your 65th birthday, if you pay the correct premium when due or within the Grace Period. Thereafter, you have the right to renew this policy on each Policy Anniversary if you are Actively At Work and you pay the correct premium when due or within the Grace Period.

Also, we reserve the right to change premiums from time to time. If we do change the premiums, we will do so only:

- (1) if we change the premiums for all policies of this same form in your state of residence;
- (2) if such change is in accordance with the laws and regulations of your state of residence; and
- (3) if we give you 31 days (45 days in North Carolina) notice before such change becomes effective.

Any change in the premium will be based on your:

- (1) age on the policy date; and
- (2) occupation class on the policy date.

INSURING CLAUSE

We will pay benefits as provided in this policy.

TEN DAY RIGHT TO EXAMINE THIS POLICY

If for any reason you decide not to keep this policy, return it to us within 10 days after you receive it. You may return it to either our home office or to the agent who sold it to you. We will treat the policy as though it never had been issued. We will refund any premium paid.

Signed for Us by:



Secretary



President

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US. READ IT CAREFULLY.

Alphabetical Guide

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POLICY SPECIFICATIONS

FORM: PPAD863
 INSURED PERSONS: DEBBORAH S JAMES

 ISSUE AGE: 36
 POLICY NUMBER: 00916014
 POLICY DATE: APRIL 01, 1990
 ANNUAL PREMIUM: \$123.48
 MODE SELECTED AT ISSUE: Quarterly
 MODE PREMIUM: \$30.87

DESCRIPTION OF COVERAGE	BENEFIT AMOUNT	ANNUAL PREMIUM
TOTAL DISABILITY DUE TO INJURY: WITH ELIMINATION OF MONTHLY BENEFIT REDUCTION RIDER Elimination Period: 180 DAYS Maximum Benefit Period**: 2 YEARS Named Insured Monthly Benefit:	\$700	\$31.08
TOTAL DISABILITY DUE TO SICKNESS: WITH ELIMINATION OF MONTHLY BENEFIT REDUCTION RIDER Elimination Period: 180 DAYS Maximum Benefit Period**: 2 YEARS Named Insured Monthly Benefit:	\$700	\$92.40

** Maximum Benefit Period May Change at Age 70. See Policy Provision.

00916014

DESCRIPTION OF COVERAGE	BENEFIT AMOUNT	ANNUAL PREMIUM
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*or appropriate state edition

PPAD86

PAGE 3A

DEFINITIONS

WHEN WE USE THE TERMS THAT FOLLOW WE MEAN:

ACTIVELY AT WORK A person is actively at work when he/she performs the normal duties of his/her principal occupation:

- a. on full-time basis (30 hours per week); and
- b. at his/her employer's usual place of business.

A person is deemed to be actively at work on each day of regular paid vacation during which he/she is not Totally Disabled, provided he/she was actively at work on the last preceding working day.

EFFECTIVE DATE This is the policy date.

ELIGIBLE DEPENDENT Unless specifically named as excluded in any part of this contract, this means:

- a. your spouse, if age 69 or under;
- b. your unmarried child under age 25 who is chiefly dependent on you for support and maintenance;
- c. your unmarried child over age 25 who is chiefly dependent on you for support and maintenance if:
 1. he/she is a full-time student at an accredited school, college, or university and we are furnished proof of such enrollment; or
 2. he/she is not able to support him/herself because of development disability, mental retardation, or physical handicap. The burden of proof that such child is and has continued to be handicapped rests with you.

ELIMINATION PERIOD The number of consecutive days for which we do not pay a monthly benefit immediately following the start of Total Disability. (See Page 3 for the number of days that apply).

HOSPITAL A lawfully operating institution which:

- a. Has resident facilities for sick and injured patients; and
- b. Mainly provides diagnostic, medical and surgical treatment for a fee to sick or injured persons (or has such treatment facilities available on a prearranged, contractual basis); and
- c. Has 24 hour nursing service by or under the supervision of a graduate registered nurse; and
- d. Has at least one physician on the staff who is on call at any time.

Or does not meet all of the above but is accredited by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities.

A hospital is not an institution or part of an institution which mainly provides convalescent, nursing, or extended care.

INJURY Bodily injury sustained by you which:

- a. is directly caused by an accident, independent of all other causes; and
- b. occurs while the policy is in force for the person on whom claim is made.

PHYSICIAN A person who:

- a. is licensed by the state in which he/she practices; and
- b. renders treatment for which benefits are provided by this policy; and
- c. acts within the scope of his/her license.

A physician does not include a family member of the insured. Family member means you, your spouse, child, sibling, parent or parent-in-law.

POLICY DATE The date shown on Page 3. It will be used to determine premium due dates.

TOTALLY DISABLED OR TOTAL DISABILITY You are totally disabled when unable, because of Injury, to perform all the substantial and material duties of your principal occupation during the first two years of disability; thereafter it means your inability, because of Injury, to perform the duties of any occupation for which you are reasonably suited by education, training or experience.

You are not totally disabled when not under the regular care of a physician (unless the physician tells us that regular care would be of no further benefit to you during such continuing disability).

WE, OUR, US refer to the Company as indicated on the cover of this Policy.

YOU, YOUR The person insured under this contract.

GENERAL AGREEMENT

We agreed to issue this policy to you because:

- a. you paid the first premium; and
- b. we relied on the answers in your application.

Your application is attached and is a part of your policy. All dealings will be between you and us.

This policy insures the Insured Persons described on Page 3 and any person added as an Insured Person after the Policy Date. Any changes to the policy will be shown by an amendment to be attached to this policy.

Each policy term begins and ends at 12:00 Noon, standard time, at the place where you reside. This policy will remain in force for any term for which premiums are paid in advance and during the Grace Period.

PREMIUMS

All premium due dates are determined from the Policy Date.

The first premium is due before we deliver the policy. All other premiums are due in advance of the term they are to cover.

You may pay premiums on any mode acceptable to us. The policy will remain in force for the term for which premiums are paid in advance.

REFUND OF UNEARNED PREMIUM

Within 30 days of proof of death of an Insured Person, we will refund any unearned premium paid for such person for any period beyond the end of the month in which death occurred.

COVERAGE & BENEFITS

TOTAL DISABILITY BENEFITS

The following is shown on Page 3:

- a. the Elimination Period applicable for Total Disabilities due to Injury; and
- b. the Monthly Benefit applicable for Total Disabilities due to Injury; and
- c. the Maximum Benefit Period applicable for any one Total Disability due to Injury, other than when you attain age 70.

MONTHLY BENEFIT

Subject to the terms of the policy, we will pay the applicable Monthly Benefit if:

- a. We receive sufficient written proof that you are Totally Disabled;
- b. You lose income due to such Total Disability;
- c. You are living.

Total Disability due to Injury must manifest itself within 30 days of the date of the accident that caused the disabling Injury.

The Monthly Benefit for Total Disability caused by Injury will begin to accrue with the first day after the Elimination Period for Injury expires. We will pay the Monthly Benefit (or part of the Monthly Benefit if less than a full month) at the end of the month for which it is due. You will get benefits as long as you are Totally Disabled, except:

- a. we will pay only up to the applicable Maximum Benefit Period for any one Total Disability. The Maximum Benefit Period may differ when you attain age 70; and
- b. any Monthly Benefit we pay will be subject to the "Monthly Benefit Reduction" provision.

MONTHLY BENEFIT REDUCTION

For any month you receive any State disability benefits including Workers Compensation Benefits and Employers Liability Benefits while entitled to a Monthly Benefit for Total Disability, the Monthly Benefit for that month will be reduced 50%.

We have the right to require reasonable proof of any such state disability benefits you receive during any month of Total Disability.

MAXIMUM BENEFIT PERIOD WHEN YOU ATTAIN AGE 70

If you are Totally Disabled when you attain age 70 and we have paid monthly benefits for less than the Maximum Benefit Period for such disability, we will continue to pay a Monthly Benefit during the period you remain Totally Disabled, for the lesser of:

- a. the balance of the applicable Maximum Benefit period; or
- b. twelve months after you attain age 70.

If you become Totally Disabled after age 70 and while your coverage is still in force, we will pay the applicable Monthly Benefit until the earliest of the following dates:

- a. the first date on which you are no longer Totally Disabled; or
- b. the date which is twelve months after the date you became Totally Disabled.

TOTAL DISABILITY FOR PART OF A MONTH

a Monthly Benefit is payable for any period of Total Disability less than a full month, we will pay One-thirtieth of the applicable Monthly Benefit for each day of Total Disability.

RECURRENT TOTAL DISABILITY

If you are Totally Disabled by the same or a related condition:

- a. more than once; and
- b. within a period of 6 months or less between each period of Total Disability; each of these periods will be considered one continuous Total Disability.

Each Total Disability must begin while this policy is in force. Only one Elimination Period will be required for such recurrent periods of Total Disability.

CONCURRENT DISABILITY

If Total Disability results from more than one cause at the same time, it will be considered the same disability and you will be entitled to a Monthly Benefit for only one Total Disability.

VAIVER OF PREMIUMS

After your Total Disability for which monthly benefits are payable has continued for 90 consecutive days, we will waive future premiums that fall due for as long as monthly benefits are payable. However, we will not waive premiums beyond the applicable Maximum Benefit Period shown on Page 3.

LIMITATIONS & EXCLUSIONS

We do not cover Total Disability or other loss caused by:

- a. injuries that are self-inflicted;
- b. travel in, or descent from, an aircraft, except when a fare-paying passenger;
- c. alcoholism or drug addiction;
- d. Injury occurring while intoxicated. (Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss is incurred);
- e. voluntary inhalation of gas;
- f. voluntarily ingesting or injecting any drug, narcotic or sedative, unless administered on the advice of and in such doses as are prescribed by a Physician;
- g. Injury sustained or Sickness which manifests itself while on full-time duty in the armed forces. Upon notice, we will refund the proportion of unearned premium paid while in such forces;
- h. Injury incurred while engaging in an illegal occupation;
- i. Injury incurred while committing or attempting to commit a felony.
- j. suicide while sane or insane;
- k. mental or emotional disorders without demonstrable organic disease.

Hernia, or any complications therefrom, is not deemed an injury.

PRE-EXISTING CONDITIONS LIMITATIONS

We do not cover Pre-existing conditions for the first two years after coverage becomes effective.

Pre-existing conditions specifically named or described as excluded in any part of this contract are never covered.

By Pre-existing condition, we mean:

- a. an Injury that pertains solely to an accidental bodily Injury which resulted from an accident sustained before the Effective Date of coverage; or
- b. any sickness which first manifested itself prior to the Effective Date of your coverage.

GENERAL PROVISIONS

ENTIRE CONTRACT & CHANGES This policy, including the application and any attachments, is the entire contract. No one has the right to change this policy unless it is approved by one of our executive officers. The approval will be attached to the policy. No agent may change this policy in any way.

TIME LIMIT ON CERTAIN DEFENSES After 2 years from the Policy Date only fraudulent misstatements in the application for this policy may be used to void the policy or deny a claim for loss incurred after the 2 year period.

GRACE PERIOD This policy has a 31-day grace period. This means that if a premium (Other than the first) is not paid on or before the date it is due, it may be paid within 31 days after it is due. During the grace period the policy will stay in force.

UNPAID PREMIUM When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

REINSTATEMENT If the renewal premium is not paid before the grace period ends, this policy will lapse. Our later acceptance of the premium without requiring an application for reinstatement will reinstate this policy.

If we require an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless we have previously written you of its disapproval.

The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than 10 days after such date. In all other respects, your rights and our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

Any premiums we accept for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days before the reinstatement date.

NOTICE OF CLAIM Written notice of claim must be given to us within 20 days (30 days in Mississippi, 60 days in Kentucky) after a covered loss starts or as soon as reasonably possible. The notice can be given to us at our home office, or to our agent. Notice should include your name and the policy number.

CLAIM FORMS When we receive the notice of claim, we will send the claimant forms for filing proof of loss. If these forms are not sent to the claimant within 15 days (10 days in Georgia), the claimant will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

PROOF OF LOSS We must be furnished written proof of loss within 90 days after the date of loss. We will not reject or reduce any claim because we are not furnished proof in the time required if it is not possible for you to do so. However, proof must be furnished as soon as reasonably possible, and in no event, no later than one year from the time proof is required, unless it is legally impossible to do so.

TIME OF PAYMENT OF CLAIMS Upon receipt of written proof of loss, we will pay the benefits then due. Any monthly payments due will be paid at the end of each month after we receive written proof of loss.

PAYMENT OF CLAIMS Loss of Life benefits, if any, will be paid to the last designated beneficiary shown in our records. If no beneficiary designation is then in effect, the benefits will be paid to the Insured Person's estate. All other benefits will be paid to you. If any accrued benefits payable to you are unpaid when you die, we may pay them to your estate or to your beneficiary. If benefits are payable to your estate or to a minor or other person not competent to give a valid release, we may pay such benefit, up to \$1,000 (\$3,000 in Florida) to any relative by blood or marriage to you who is deemed entitled to the benefits.

If we make a payment in good faith under this provision, such payment will discharge us to its extent.

LEGAL ACTION No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years (after the applicable statute of limitations in Florida, after 6 years in South Carolina) from the time written proof of loss is required to be given.

PHYSICAL EXAMINATIONS AND AUTOPSY At our expense, we have the right to have the Insured Person examined as often as reasonably necessary while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

MISSTATEMENT OF AGE If the age of an Insured Person has been misstated, we will pay only such amounts as the premium paid would have purchased at the correct age. In the event an Insured Person's age was overstated, we will refund any premium that may be due when we have been notified of this fact. Our liability shall be limited to the refund of the premium paid for the term not covered by the policy if:

- a. as the result of misstatement of the age of an Insured Person, we accept premium for a term beyond the date the coverage would have ceased; or
- b. according to the correct age the coverage would not have become effective for any reason.

CONFORMITY WITH STATE STATUTE Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the state in which you reside on such date is amended to conform to the minimum requirements of such statutes.

CHANGE OF BENEFICIARY You may change your beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

IMPORTANT NOTICE

Please carefully read your policy and the copy of the application attached to it. If any information shown on it is not correct and complete, or if any medical history has been left out of the application, immediately write to us. This application is a part of the policy which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

DISABILITY INCOME POLICY

**GUARANTEED RENEWABLE TO AGE 65.
SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS.**

PROFESSIONAL INSURANCE COMPANY

Home Office: Dallas, TX 75201

Administrative Office: 175 Addison Rd, P.O. Box 725, Windsor, CT 06095-0725 • 800-289-1122

ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached. The Policy is amended as follows:

The **PRE-EXISTING CONDITIONS LIMITATIONS** provision is hereby deleted and replaced with the following:

PRE-EXISTING CONDITIONS LIMITATIONS

This policy and any attached riders do not cover losses incurred or any period of disability which commenced during the first year of coverage if such loss or period of disability was caused by a Pre-existing Condition, whether disclosed on the application or not.

Pre-existing Conditions specifically named or described as excluded in any part of this contract are never covered.

By Pre-existing Condition, we mean:

- a. The existence of symptoms during the one year period before the Effective Date of your coverage which would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment; or
- b. Any sickness, disease or physical condition for which medical advice or treatment was recommended by or received from a Physician during the one year period preceding the Effective Date of your coverage.

The definition of **PHYSICIAN** is hereby deleted and replaced with the following:

PHYSICIAN means a duly licensed practitioner of the healing arts practicing within the scope of his/her license. A Physician does not include a family member of the Insured. Family member means you, your spouse, children, grandchildren, siblings, parents, grandparents, or corresponding in-laws.

The **LIMITATIONS AND EXCLUSIONS** provision is amended by deleting the exclusion which reads:

- a. injuries that are self-inflicted;

and replacing it with the following:

- a. injuries that are intentionally self-inflicted;

This Endorsement shall not otherwise alter, waive, or amend any of the terms or conditions of this policy.

We have issued this Endorsement on the Policy Date.



Secretary

PROFESSIONAL INSURANCE COMPANY

Home Office: Dallas, TX 75201

Administrative Office: 175 Addison Rd, P.O. Box 725, Windsor, CT 06095-0725 • 800-289-1122

ELIMINATION OF MONTHLY BENEFIT REDUCTION RIDER

We have issued this rider to you because:

- a. You paid the initial additional premium to provide its coverage; and
- b. We relied on the application You made.

The policy to which this Rider is attached is amended as follows:

- a. The following term is added to the **DEFINITIONS**:

WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY BENEFITS

Those benefits that are payable pursuant to a requirement of the Worker's Compensation or Employer's Liability Laws, whether payable through the State fund or approved private insurance coverage, self insurance coverage or other funding mechanism.

- b. The **MONTHLY BENEFIT REDUCTION** provision is hereby deleted in its entirety to provide the following benefit:

For any month You are entitled to a Monthly Benefit for Total Disability, We will pay the applicable Monthly Benefit in addition to any Worker's Compensation Benefits, Employer's Liability Benefits or other State disability benefits You receive.

Any Monthly Benefit We pay is subject to the terms of the Monthly Benefit provision.

- c. Exception (b.) of the **MONTHLY BENEFIT** provision is deleted in its entirety in accordance with the benefit provided by this Rider.

Other than as stated above, this rider will not alter any other provision of the policy to which it is attached.



Secretary

PROFESSIONAL INSURANCE COMPANY

Home Office: Dallas, TX 75201

Administrative Office: 175 Addison Rd, P.O. Box 725, Windsor, CT 06095-0725 • 800-289-1122

TOTAL DISABILITY – SICKNESS RIDER

AGREEMENT

This rider is a part of the policy to which it is attached. We have issued this rider to you because:

- a. you paid the additional premium for this rider; and
- b. we relied on the application you made.

Unless shown in the Rider Schedule below, the Rider Date of this Rider is the Policy Date, and the Monthly Benefit Amount, Annual Premium, Maximum Benefit Period, Elimination Period and Issue Age of this rider are as shown on page 3 of the policy.

Unless amended by this rider, Policy Definitions and Terms apply to this rider.

RIDER SCHEDULE

The Rider Schedule Table is only to be completed if this Rider is attached after the Policy Date.

RIDER SCHEDULE						
Policy Number	Rider Date MM/DD/YY	Monthly Benefit	Annual Premium	Issue Age	Elimination Period	Maximum Benefit Period

This policy to which this rider is attached is amended as follows:

1. The Definition of Totally Disabled or Total Disability is deleted and replaced by the following:

TOTALLY DISABLED OR TOTAL DISABILITY You are Totally Disabled when unable, because of Injury or Sickness, to perform all the substantial material duties of your principal occupation during the first two years of disability; thereafter it means your inability, because of Injury or Sickness, to perform the duties of any occupation for which you are reasonably suited by education, training or experience.

You are not totally disabled when not under the regular care of a physician (unless the physician tells us that regular care would be of no further benefit to you during such continuing disability).

SICKNESS A disease or illness which first manifests itself after the coverage becomes effective for the person insured.

2. The following is added to the **TOTAL DISABILITY BENEFITS** provision:

- d. the Elimination Period applicable for Total Disabilities due to Sickness;
- e. the Monthly Benefit applicable for Total Disabilities due to Sickness;
- f. the Maximum Benefit Period applicable for any one Total Disability due to Sickness.

3. The following paragraph is added to the **MONTHLY BENEFIT** provision:

If the Elimination Period for Total Disability due to Sickness is less than 15 days then the Monthly Benefit for Total Disability caused by Sickness will begin to accrue:

- a. on the day you are admitted to the Hospital, as a resident patient for at least 24 hours, for the disabling Sickness; or
- b. with the first day after the Elimination Period for Sickness expires; whichever is earlier.

If the Elimination Period for Total Disability due to Sickness is 15 days or more then the applicable Monthly Benefit will begin to accrue with the first day after the Elimination Period for Sickness expires.

TERMINATION

This rider terminates:

- a. when your coverage terminates under the Policy to which this rider is attached;
- b. when any premium for this rider is not paid before the end of the grace period; or
- c. when you give us a written request to do so.

PREMIUMS

While this rider is in effect, premiums are due according to the terms of the policy.

We reserve the right to change the premiums for this rider. If we decide to change the premiums, we will do so only;

- a. if we change the premiums for all riders of this same form in your state of residence;
- b. if such change is in accordance with the laws and regulations of your state of residence; and
- c. if we give you 31 days (45 days in North Carolina) notice before such change becomes effective.

Other than as stated above, this rider will not alter any other provision of the policy to which it is attached.

A handwritten signature in black ink, appearing to read "William D. Blum". The signature is fluid and cursive, with a long horizontal stroke at the end.

Secretary

PROFESSIONAL INSURANCE COMPANY

Home Office: Dallas, TX 75201

Administrative Office: 175 Addison Rd, P.O. Box 725, Windsor, CT 06095-0725 • 800-289-1122

NOTICE TO POLICYHOLDER

Any questions concerning this policy may be addressed to:

**PROFESSIONAL INSURANCE COMPANY
PO Box 80637
Lincoln, NE 68501
TELEPHONE: (800) 289-1122**

DEBBORAH S JAMES
1620 TERRACE DRIVE
LOUDON, TN 37774

PROFESSIONAL INSURANCE COMPANY

Home Office: Dallas, TX 75201

Administrative Office: 175 Addison Rd, P.O. Box 725, Windsor, CT 06095-0725 • 800-289-1122

Welcome to Professional Insurance Company, now a part of Sun Life Employee Benefits Group. For over 65 years, Professional Insurance Company has provided high quality, affordable supplemental insurance benefits to employees of small-to medium-sized businesses.

We are happy to enclose your new policy. Your new benefits were designed to help you enjoy greater peace of mind in the years to come.

Before you put your policy in a safe place, please read it carefully, including the copy of the application, to be sure you understand the policy provisions. Please notify us immediately if:

- you have questions about your coverage;
- there is any misstatement in the application, even though unintentional, or;
- any information about an insured person's medical history has been omitted or is inaccurate.

We look forward to serving you and appreciate the confidence you have placed in us. If you have any questions now or in the future, please write to our Policyholder's Service Department, or contact us at the telephone number listed above.



President

- 02289

DEBBORAH S JAMES
1620 TERRACE DRIVE
LOUDON, TN 37774

EFSWELCAH-F

Cut along dotted line and retain for identification

PROFESSIONAL INSURANCE COMPANY

This card identifies a Professional Insurance Company policyholder. Pre-certification is not required when the policyholder is hospitalized for any accident or sickness. A health care provider may confirm coverage provided by this policy by calling our Claim Department at the number listed below.

DEBBORAH S JAMES
00916015

1-800-289-1122
PO Box 80637 Lincoln, NE 68501

PROFESSIONAL INSURANCE COMPANY

This card identifies a Professional Insurance Company policyholder. Pre-certification is not required when the policyholder is hospitalized for any accident or sickness. A health care provider may confirm coverage provided by this policy by calling our Claim Department at the number listed below.

DEBBORAH S JAMES
00916015

1-800-289-1122
PO Box 80637 Lincoln, NE 68501



Professional Insurance Company
In California, PIC Life Insurance Company
P.O. Box 80637, Lincoln, NE 68501

Privacy Notice

Professional Insurance Company
In California, PIC Life Insurance Company

Important information. No action required.

At Sun Life Financial and our family of companies, we appreciate your business and the trust you have placed in us. Our privacy philosophy reflects the value of your trust. We are committed to protecting the personal information (data) we obtain about you. We do not sell your data and we only use your data in the context of our business relationship. To further understand our Privacy Policy please review the following details.

The data we collect

We collect your data to provide you with the products or services you requested. We may obtain it from your application, your transactions with us, outside parties such as health providers, or consumer reporting agencies. We may collect data about you to process transactions or claims, to determine if you qualify for coverage, and to prevent fraud. Where required, we will obtain your consent before collecting it. The data may include:

- Name and address
- Social security number or taxpayer identification number
- Income and assets
- Accounts at other institutions
- Medical or health data
- Credit and payment data

What we do with your data

We comply with federal and state requirements related to the use and protection of your data. We only share data where we are permitted or required by law. We also may be required to obtain your authorization before disclosing certain types of data.

We may use your data in order to:

- Process transactions or claims
- Determine your eligibility for coverage
- Respond to your requests
- Prevent fraud
- Comply with regulatory requirements
- Share with you related products and services we offer

We do not sell data about current or former customers or their accounts. We do not share data for marketing purposes with anyone outside our family of companies. When affiliates or outside companies perform a service on our behalf, we may share your data with them. They are required to protect your data. These service providers are also required to use your data only to perform these services.

Examples of outside parties who may receive your data are:

- Your agent or representative
- Your brokerage firm
- Law enforcement
- State insurance, health care, or law enforcement authorities
- Other insurance companies
- Other carriers to coordinate benefits for your coverage
- Service providers for our business
- Your health care provider

How we protect your data

We restrict access to your data. To protect your data, we maintain physical, electronic, and procedural safeguards. We review these safeguards regularly in keeping with technological advancements. We also train our employees in the proper handling of your data.

We will keep you informed

We will send you the Policy each year while you are our customer. We may change our Policy. We will send you a new Policy if we broaden our data sharing practices.

Professional Insurance Company
In California, PIC Life Insurance Company

HOW TO FILE A CLAIM

DISABILITY CLAIMS

When you need to file a PIC Disability claim:

1. Call 1-800-289-1122 to obtain a claim packet. The claim packet will contain a claim form, an authorization form, and a request for a list of providers.
2. FULLY COMPLETE the Claimant's portion of the claim form. Please sign and date the authorization. Include your policy number and social security number.
3. Have your Employer FULLY COMPLETE and SIGN the Employer's section of the claim form.
4. Have your doctor fully complete the Attending Physician's portion of the claim form.
5. In order to assist us in reviewing your claim as quickly as possible, please complete the Authorization to Obtain and Disclose Protected Health Information and Request for Additional Medical Information.
6. Send the fully completed forms to the address below.
7. Do not complete and/or submit your claim form prior to your disability.

HOSPITAL INDEMNITY/CANCER CLAIMS

When you need to file a Hospital Indemnity/Cancer claim:

1. Call 1-800-289-1122 to obtain a claim packet. The claim packet will contain a claim form, an authorization form, and a request for a list of providers.
2. FULLY COMPLETE the Claimant's portion of the claim form. Please sign and date the authorization. Include your policy number and patient information (Name, SSN and Date of Birth). Please also complete the enclosed authorization and request for additional medical information.
3. Attach copies of the following – UB-92 forms (hospital bills), HCFA forms (physician bills) or itemized bills that provide Dates of Service, Type of Service, Diagnosis and charges. NOTE: The UB-92 and HCFA forms allow for the quickest processing. You can ask your Doctor and/or hospital to provide these to you.
4. For Cancer claims, in addition to the items listed above, submit a copy of the positive pathology report.
5. Send the fully completed forms to the address below.

Taking these steps will insure that a claim will be processed as accurately and quickly as possible.

Professional Insurance Company
Employer Services Group
Claims Department
P.O. Box 85656
Lincoln, NE 68501-5656

PROFESSIONAL INSURANCE COMPANY

Home Office: Dallas, TX 75201

Administrative Office: 175 Addison Rd, P.O. Box 725, Windsor, CT 06095-0725 • 800-289-1122

DISABILITY INCOME POLICY

GUARANTEED RENEWABLE TO AGE 65. SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS.

You have the right to renew this policy until the first premium due date on or after your 65th birthday, if you pay the correct premium when due or within the Grace Period. Thereafter, you have the right to renew this policy on each Policy Anniversary if you are Actively At Work and you pay the correct premium when due or within the Grace Period.

Also, we reserve the right to change premiums from time to time. If we do change the premiums, we will do so only:

- (1) if we change the premiums for all policies of this same form in your state of residence;
- (2) if such change is in accordance with the laws and regulations of your state of residence; and
- (3) if we give you 31 days (45 days in North Carolina) notice before such change becomes effective.

Any change in the premium will be based on your:

- (1) age on the policy date; and
- (2) occupation class on the policy date.

INSURING CLAUSE

We will pay benefits as provided in this policy.

TEN DAY RIGHT TO EXAMINE THIS POLICY

If for any reason you decide not to keep this policy, return it to us within 10 days after you receive it. You may return it to either our home office or to the agent who sold it to you. We will treat the policy as though it never had been issued. We will refund any premium paid.

Signed for Us by:



Secretary



President

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US. READ IT CAREFULLY.

Alphabetical Guide

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Contract Provisions

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POLICY SPECIFICATIONS

FORM: PPAD863
 INSURED PERSONS: DEBBORAH S JAMES
 ISSUE AGE: 36
 POLICY NUMBER: 00916015
 POLICY DATE: APRIL 01, 1990
 ANNUAL PREMIUM: \$142.08
 MODE SELECTED AT ISSUE: Quarterly
 MODE PREMIUM: \$35.52

DESCRIPTION OF COVERAGE	BENEFIT AMOUNT	ANNUAL PREMIUM
TOTAL DISABILITY DUE TO INJURY: WITH ELIMINATION OF MONTHLY BENEFIT REDUCTION RIDER Elimination Period: 180 DAYS Maximum Benefit Period**: 2 YEARS Named Insured Monthly Benefit:	\$800	\$36.48
TOTAL DISABILITY DUE TO SICKNESS: WITH ELIMINATION OF MONTHLY BENEFIT REDUCTION RIDER Elimination Period: 180 DAYS Maximum Benefit Period**: 2 YEARS Named Insured Monthly Benefit:	\$800	\$105.60

** Maximum Benefit Period May Change at Age 70. See Policy Provision.

00916015

DESCRIPTION OF COVERAGE

BENEFIT
AMOUNT

ANNUAL
PREMIUM

*or appropriate state edition

PPAD86

PAGE 3A

DEFINITIONS

WHEN WE USE THE TERMS THAT FOLLOW WE MEAN:

ACTIVELY AT WORK A person is actively at work when he/she performs the normal duties of his/her principal occupation:

- a. on full-time basis (30 hours per week); and
- b. at his/her employer's usual place of business.

A person is deemed to be actively at work on each day of regular paid vacation during which he/she is not Totally Disabled, provided he/she was actively at work on the last preceding working day.

EFFECTIVE DATE This is the policy date.

ELIGIBLE DEPENDENT Unless specifically named as excluded in any part of this contract, this means:

- a. your spouse, if age 69 or under;
- b. your unmarried child under age 25 who is chiefly dependent on you for support and maintenance;
- c. your unmarried child over age 25 who is chiefly dependent on you for support and maintenance if:
 1. he/she is a full-time student at an accredited school, college, or university and we are furnished proof of such enrollment; or
 2. he/she is not able to support him/herself because of development disability, mental retardation, or physical handicap. The burden of proof that such child is and has continued to be handicapped rests with you.

ELIMINATION PERIOD The number of consecutive days for which we do not pay a monthly benefit immediately following the start of Total Disability. (See Page 3 for the number of days that apply).

HOSPITAL A lawfully operating institution which:

- a. Has resident facilities for sick and injured patients; and
- b. Mainly provides diagnostic, medical and surgical treatment for a fee to sick or injured persons (or has such treatment facilities available on a prearranged, contractual basis); and
- c. Has 24 hour nursing service by or under the supervision of a graduate registered nurse; and
- d. Has at least one physician on the staff who is on call at any time.

Or does not meet all of the above but is accredited by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities.

A hospital is not an institution or part of an institution which mainly provides convalescent, nursing, or extended care.

INJURY Bodily injury sustained by you which:

- a. is directly caused by an accident, independent of all other causes; and
- b. occurs while the policy is in force for the person on whom claim is made.

PHYSICIAN A person who:

- a. is licensed by the state in which he/she practices; and
- b. renders treatment for which benefits are provided by this policy; and
- c. acts within the scope of his/her license.

A physician does not include a family member of the insured. Family member means you, your spouse, child, sibling, parent or parent-in-law.

POLICY DATE The date shown on Page 3. It will be used to determine premium due dates.

TOTALLY DISABLED OR TOTAL DISABILITY You are totally disabled when unable, because of Injury, to perform all the substantial and material duties of your principal occupation during the first two years of disability; thereafter it means your inability, because of Injury, to perform the duties of any occupation for which you are reasonably suited by education, training or experience.

You are not totally disabled when not under the regular care of a physician (unless the physician tells us that regular care would be of no further benefit to you during such continuing disability).

WE, OUR, US refer to the Company as indicated on the cover of this Policy.

YOU, YOUR The person insured under this contract.

GENERAL AGREEMENT

We agreed to issue this policy to you because:

- a. you paid the first premium; and
- b. we relied on the answers in your application.

Your application is attached and is a part of your policy. All dealings will be between you and us.

This policy insures the Insured Persons described on Page 3 and any person added as an Insured Person after the Policy Date. Any changes to the policy will be shown by an amendment to be attached to this policy.

Each policy term begins and ends at 12:00 Noon, standard time, at the place where you reside. This policy will remain in force for any term for which premiums are paid in advance and during the Grace Period.

PREMIUMS

All premium due dates are determined from the Policy Date.

The first premium is due before we deliver the policy. All other premiums are due in advance of the term they are to cover.

You may pay premiums on any mode acceptable to us. The policy will remain in force for the term for which premiums are paid in advance.

REFUND OF UNEARNED PREMIUM

Within 30 days of proof of death of an Insured Person, we will refund any unearned premium paid for such person for any period beyond the end of the month in which death occurred.

COVERAGE & BENEFITS

TOTAL DISABILITY BENEFITS

The following is shown on Page 3:

- a. the Elimination Period applicable for Total Disabilities due to Injury; and
- b. the Monthly Benefit applicable for Total Disabilities due to Injury; and
- c. the Maximum Benefit Period applicable for any one Total Disability due to Injury, other than when you attain age 70.

MONTHLY BENEFIT

Subject to the terms of the policy, we will pay the applicable Monthly Benefit if:

- a. We receive sufficient written proof that you are Totally Disabled;
- b. You lose income due to such Total Disability;
- c. You are living.

Total Disability due to Injury must manifest itself within 30 days of the date of the accident that caused the disabling Injury.

The Monthly Benefit for Total Disability caused by Injury will begin to accrue with the first day after the Elimination Period for Injury expires. We will pay the Monthly Benefit (or part of the Monthly Benefit if less than a full month) at the end of the month for which it is due. You will get benefits as long as you are Totally Disabled, except:

- a. we will pay only up to the applicable Maximum Benefit Period for any one Total Disability. The Maximum Benefit Period may differ when you attain age 70; and
- b. any Monthly Benefit we pay will be subject to the "Monthly Benefit Reduction" provision.

MONTHLY BENEFIT REDUCTION

For any month you receive any State disability benefits including Workers Compensation Benefits and Employers Liability Benefits while entitled to a Monthly Benefit for Total Disability, the Monthly Benefit for that month will be reduced 50%.

We have the right to require reasonable proof of any such state disability benefits you receive during any month of Total Disability.

MAXIMUM BENEFIT PERIOD WHEN YOU ATTAIN AGE 70

If you are Totally Disabled when you attain age 70 and we have paid monthly benefits for less than the Maximum Benefit Period for such disability, we will continue to pay a Monthly Benefit during the period you remain Totally Disabled, for the lesser of:

- a. the balance of the applicable Maximum Benefit period; or
- b. twelve months after you attain age 70.

If you become Totally Disabled after age 70 and while your coverage is still in force, we will pay the applicable Monthly Benefit until the earliest of the following dates:

- a. the first date on which you are no longer Totally Disabled; or
- b. the date which is twelve months after the date you became Totally Disabled.

TOTAL DISABILITY FOR PART OF A MONTH

A Monthly Benefit is payable for any period of Total Disability less than a full month, we will pay One-thirtieth of the applicable Monthly Benefit for each day of Total Disability.

RECURRENT TOTAL DISABILITY

If you are Totally Disabled by the same or a related condition:

- a. more than once; and
- b. within a period of 6 months or less between each period of Total Disability; each of these periods will be considered one continuous Total Disability.

Each Total Disability must begin while this policy is in force. Only one Elimination Period will be required for such recurrent periods of Total Disability.

CONCURRENT DISABILITY

If Total Disability results from more than one cause at the same time, it will be considered the same disability and you will be entitled to a Monthly Benefit for only one Total Disability.

WAIVER OF PREMIUMS

After your Total Disability for which monthly benefits are payable has continued for 90 consecutive days, we will waive future premiums that fall due for as long as monthly benefits are payable. However, we will not waive premiums beyond the applicable Maximum Benefit Period shown on Page 3.

LIMITATIONS & EXCLUSIONS

We do not cover Total Disability or other loss caused by:

- a. injuries that are self-inflicted;
- b. travel in, or descent from, an aircraft, except when a fare-paying passenger;
- c. alcoholism or drug addiction;
- d. Injury occurring while intoxicated. (Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss is incurred);
- e. voluntary inhalation of gas;
- f. voluntarily ingesting or injecting any drug, narcotic or sedative, unless administered on the advice of and in such doses as are prescribed by a Physician;
- g. Injury sustained or Sickness which manifests itself while on full-time duty in the armed forces. Upon notice, we will refund the proportion of unearned premium paid while in such forces;
- h. Injury incurred while engaging in an illegal occupation;
- i. Injury incurred while committing or attempting to commit a felony.
- j. suicide while sane or insane;
- k. mental or emotional disorders without demonstrable organic disease.

Hernia, or any complications therefrom, is not deemed an injury.

PRE-EXISTING CONDITIONS LIMITATIONS

We do not cover Pre-existing conditions for the first two years after coverage becomes effective.

Pre-existing conditions specifically named or described as excluded in any part of this contract are never covered.

By Pre-existing condition, we mean:

- a. an Injury that pertains solely to an accidental bodily Injury which resulted from an accident sustained before the Effective Date of coverage; or
- b. any sickness which first manifested itself prior to the Effective Date of your coverage.

GENERAL PROVISIONS

ENTIRE CONTRACT & CHANGES This policy, including the application and any attachments, is the entire contract. No one has the right to change this policy unless it is approved by one of our executive officers. The approval will be attached to the policy. No agent may change this policy in any way.

TIME LIMIT ON CERTAIN DEFENSES After 2 years from the Policy Date only fraudulent misstatements in the application for this policy may be used to void the policy or deny a claim for loss incurred after the 2 year period.

GRACE PERIOD This policy has a 31-day grace period. This means that if a premium (Other than the first) is not paid on or before the date it is due, it may be paid within 31 days after it is due. During the grace period the policy will stay in force.

UNPAID PREMIUM When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

REINSTATEMENT If the renewal premium is not paid before the grace period ends, this policy will lapse. Our later acceptance of the premium without requiring an application for reinstatement will reinstate this policy.

If we require an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless we have previously written you of its disapproval.

The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than 10 days after such date. In all other respects, your rights and our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

Any premiums we accept for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days before the reinstatement date.

NOTICE OF CLAIM Written notice of claim must be given to us within 20 days (30 days in Mississippi, 60 days in Kentucky) after a covered loss starts or as soon as reasonably possible. The notice can be given to us at our home office, or to our agent. Notice should include your name and the policy number.

CLAIM FORMS When we receive the notice of claim, we will send the claimant forms for filing proof of loss. If these forms are not sent to the claimant within 15 days (10 days in Georgia), the claimant will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

PROOF OF LOSS We must be furnished written proof of loss within 90 days after the date of loss. We will not reject or reduce any claim because we are not furnished proof in the time required if it is not possible for you to do so. However, proof must be furnished as soon as reasonably possible, and in no event, no later than one year from the time proof is required, unless it is legally impossible to do so.

TIME OF PAYMENT OF CLAIMS Upon receipt of written proof of loss, we will pay the benefits then due. Any monthly payments due will be paid at the end of each month after we receive written proof of loss.

PAYMENT OF CLAIMS Loss of Life benefits, if any, will be paid to the last designated beneficiary shown in our records. If no beneficiary designation is then in effect, the benefits will be paid to the Insured Person's estate. All other benefits will be paid to you. If any accrued benefits payable to you are unpaid when you die, we may pay them to your estate or to your beneficiary. If benefits are payable to your estate or to a minor or other person not competent to give a valid release, we may pay such benefit, up to \$1,000 (\$3,000 in Florida) to any relative by blood or marriage to you who is deemed entitled to the benefits.

If we make a payment in good faith under this provision, such payment will discharge us to its extent.

LEGAL ACTION No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years (after the applicable statute of limitations in Florida, after 6 years in South Carolina) from the time written proof of loss is required to be given.

PHYSICAL EXAMINATIONS AND AUTOPSY At our expense, we have the right to have the Insured Person examined as often as reasonably necessary while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

MISSTATEMENT OF AGE If the age of an Insured Person has been misstated, we will pay only such amounts as the premium paid would have purchased at the correct age. In the event an Insured Person's age was overstated, we will refund any premium that may be due when we have been notified of this fact. Our liability shall be limited to the refund of the premium paid for the term not covered by the policy if:

- a. as the result of misstatement of the age of an Insured Person, we accept premium for a term beyond the date the coverage would have ceased; or
- b. according to the correct age the coverage would not have become effective for any reason.

CONFORMITY WITH STATE STATUTE Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the state in which you reside on such date is amended to conform to the minimum requirements of such statutes.

CHANGE OF BENEFICIARY You may change your beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

IMPORTANT NOTICE

Please carefully read your policy and the copy of the application attached to it. If any information shown on it is not correct and complete, or if any medical history has been left out of the application, immediately write to us. This application is a part of the policy which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

DISABILITY INCOME POLICY

**GUARANTEED RENEWABLE TO AGE 65.
SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS.**

PROFESSIONAL INSURANCE COMPANY

Home Office: Dallas, TX 75201

Administrative Office: 175 Addison Rd, P.O. Box 725, Windsor, CT 06095-0725 • 800-289-1122

ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached. The Policy is amended as follows:

The **PRE-EXISTING CONDITIONS LIMITATIONS** provision is hereby deleted and replaced with the following:

PRE-EXISTING CONDITIONS LIMITATIONS

This policy and any attached riders do not cover losses incurred or any period of disability which commenced during the first year of coverage if such loss or period of disability was caused by a Pre-existing Condition, whether disclosed on the application or not.

re-existing Conditions specifically named or described as excluded in any part of this contract are never covered.

By Pre-existing Condition, we mean:

- a. The existence of symptoms during the one year period before the Effective Date of your coverage which would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment; or
- b. Any sickness, disease or physical condition for which medical advice or treatment was recommended by or received from a Physician during the one year period preceding the Effective Date of your coverage.

The definition of **PHYSICIAN** is hereby deleted and replaced with the following:

PHYSICIAN means a duly licensed practitioner of the healing arts practicing within the scope of his/her license. A Physician does not include a family member of the Insured. Family member means you, your spouse, children, grandchildren, siblings, parents, grandparents, or corresponding in-laws.

The **LIMITATIONS AND EXCLUSIONS** provision is amended by deleting the exclusion which reads:

- a. injuries that are self-inflicted;

and replacing it with the following:

- a. injuries that are intentionally self-inflicted;

This Endorsement shall not otherwise alter, waive, or amend any of the terms or conditions of this policy.

We have issued this Endorsement on the Policy Date.



Secretary

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ELIMINATION OF MONTHLY BENEFIT REDUCTION RIDER

We have issued this rider to you because:

- a. You paid the initial additional premium to provide its coverage; and
- b. We relied on the application You made.

The policy to which this Rider is attached is amended as follows:

- a. The following term is added to the **DEFINITIONS**:

WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY BENEFITS

Those benefits that are payable pursuant to a requirement of the Worker's Compensation or Employer's Liability Laws, whether payable through the State fund or approved private insurance coverage, self insurance coverage or other funding mechanism.

- b. The **MONTHLY BENEFIT REDUCTION** provision is hereby deleted in its entirety to provide the following benefit:

For any month You are entitled to a Monthly Benefit for Total Disability, We will pay the applicable Monthly Benefit in addition to any Worker's Compensation Benefits, Employer's Liability Benefits or other State disability benefits You receive.

Any Monthly Benefit We pay is subject to the terms of the Monthly Benefit provision.

- c. Exception (b.) of the **MONTHLY BENEFIT** provision is deleted in its entirety in accordance with the benefit provided by this Rider.

Other than as stated above, this rider will not alter any other provision of the policy to which it is attached.



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TOTAL DISABILITY – SICKNESS RIDER

AGREEMENT

This rider is a part of the policy to which it is attached. We have issued this rider to you because:

- a. you paid the additional premium for this rider; and
- b. we relied on the application you made.

Unless shown in the Rider Schedule below, the Rider Date of this Rider is the Policy Date, and the Monthly Benefit Amount, Annual Premium, Maximum Benefit Period, Elimination Period and Issue Age of this rider are as shown on page 3 of the policy.

Unless amended by this rider, Policy Definitions and Terms apply to this rider.

RIDER SCHEDULE

The Rider Schedule Table is only to be completed if this Rider is attached after the Policy Date.

RIDER SCHEDULE						
Policy Number	Rider Date MM/DD/YY	Monthly Benefit	Annual Premium	Issue Age	Elimination Period	Maximum Benefit Period

This policy to which this rider is attached is amended as follows:

1. The Definition of Totally Disabled or Total Disability is deleted and replaced by the following:

TOTALLY DISABLED OR TOTAL DISABILITY You are Totally Disabled when unable, because of Injury or Sickness, to perform all the substantial material duties of your principal occupation during the first two years of disability; thereafter it means your inability, because of Injury or Sickness, to perform the duties of any occupation for which you are reasonably suited by education, training or experience.

You are not totally disabled when not under the regular care of a physician (unless the physician tells us that regular care would be of no further benefit to you during such continuing disability).

SICKNESS A disease or illness which first manifests itself after the coverage becomes effective for the person insured.

2. The following is added to the **TOTAL DISABILITY BENEFITS** provision:

- d. the Elimination Period applicable for Total Disabilities due to Sickness;
- e. the Monthly Benefit applicable for Total Disabilities due to Sickness;
- f. the Maximum Benefit Period applicable for any one Total Disability due to Sickness.

3. The following paragraph is added to the **MONTHLY BENEFIT** provision:

If the Elimination Period for Total Disability due to Sickness is less than 15 days then the Monthly Benefit for Total Disability caused by Sickness will begin to accrue:

- a. on the day you are admitted to the Hospital, as a resident patient for at least 24 hours, for the disabling Sickness; or
- b. with the first day after the Elimination Period for Sickness expires; whichever is earlier.

If the Elimination Period for Total Disability due to Sickness is 15 days or more then the applicable Monthly Benefit will begin to accrue with the first day after the Elimination Period for Sickness expires.

TERMINATION

This rider terminates:

- a. when your coverage terminates under the Policy to which this rider is attached;
- b. when any premium for this rider is not paid before the end of the grace period; or
- c. when you give us a written request to do so.

PREMIUMS

While this rider is in effect, premiums are due according to the terms of the policy.

We reserve the right to change the premiums for this rider. If we decide to change the premiums, we will do so only;

- a. if we change the premiums for all riders of this same form in your state of residence;
- b. if such change is in accordance with the laws and regulations of your state of residence; and
- c. if we give you 31 days (45 days in North Carolina) notice before such change becomes effective.

Other than as stated above, this rider will not alter any other provision of the policy to which it is attached.



Secretary

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NOTICE TO POLICYHOLDER

Any questions concerning this policy may be addressed to:

**PROFESSIONAL INSURANCE COMPANY
PO Box 80637
Lincoln, NE 68501
TELEPHONE: (800) 289-1122**